SEXUAL-INCAPACITY THERAPY

EDWARD A. TYLER

American Handbook of Psychiatry

Sexual-Incapacity Therapy

Edward A. Tyler

e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 5* edited by Silvano Arieti, Daniel X. Freedman, Jarl E. Dyrud

Table of Contents

SEXUAL-INCAPACITY THERAPY

Therapeutic measures for human sexual incapacities are as old as recorded history. Documentation usually appeared in vignettes concerning persons of status, fame, or notoriety (Hastings, 1963; Johnson, 1968; Taylor, 1954; Taylor, 1900). These persons were almost exclusively males, since, until this century, women were defined as having low or no sexual (Gibbons, 1923), intellectual, or achievement drives. In contrast, the potency and virility of men was believed to be positively correlated with their bravery, leadership ability, competence as soldiers, influence with the gods, etc. Known or rumored impotence in a king or tribal leader could lead to his being expelled, killed, or replaced. Not only were leaders supposed to produce heirs, but crop failures, poor hunting and fishing harvests, lack of rain, losses in battle were often attributed to a male leader's impotence or lack of virility. It was believed that a witch or the devil could cast a spell of impotence on a man. The witch was believed to use such devices as an invisible ligature around the base of the penis of the afflicted male. With this etiology, the logical treatment was to destroy the hapless woman accused of being the guilty witch.

As recently as the first part of the twentieth century, the Christian world subscribed to a moralistic etiology (Taylor, 1900). It was believed to be God's punishment or, at least, a deserved consequence of sexual excesses such as masturbation (self-abuse [Pullias, 1937]), "excessive" sexual excitement

during courtship, "excessive" coitus, "unnatural" prolongation of coitus (for the alleged greater gratification of the female), "abnormal" coital positions, and sexual activities with lascivious females. "Therapies" were prescribed by priests (penances), mystics (love potions), and by physicians (advice and pharmaceuticals). In 1900, an authoritative book (Taylor, 1900) recommended that "the first indication is to determine what is the morbid factor and when discovered to treat it on general medical principles . . . some benefit may follow the judicious installation of strong nitrate of silver solution into the prostatic urethra. . . . In some cases much benefit is produced by the ingestion of a combination of atropine and strychnine. . . . Quinine in three grain doses given three times a day, particularly in combination with strychnine, and in very atonic cases with atropine is sometimes of marked beneficial affect. . . . A preparation composed of various animal extracts, known as phospho-albumen acts as a decided sexual tonic in some cases. . . . Chloride of gold and sodium administered in the form of pills in doses of one-twentieth of a grain, three times a day, have been vaunted by several authors of having marked aphrodisiac power," and so on. Almost every imaginable "witch's brew" and magic "love potion" as well as innumerable physical manipulations of the penis, perineum, prostate, testicles, and rectum were tried without notable or predictable success.

From the early nineteen thirties until the mid-sixties, psychodynamic psychotherapy became the treatment of choice (Condrau, 1960; Deutsch,

1965; Ferenczi, 1956; Flick, 1969; Freud, 1955; Glen, 1968; Moore, 1964). Results were neither impressive nor consistent. Insight and/or acceptance of one's incapacities were acceptable outcomes of therapy. During the sixties, Masters and Johnson (1968; 1970) reported on a technique that offered a significantly high and predictable rate of success in improving the sexual interest and performance of sexually incapacited women and men. About the same time there were reports (Brady, 1966; Dengrove, 1967; Haslam, 1965; Rachman, 1961) of successful therapy using the behavior-therapy techniques of Wolpe and Eysenck. These two therapeutic regimes have some common objectives that will be discussed later.

Definitions

Before discussing specific therapeutic principles, objectives, techniques, and outcomes, it is necessary to operationally define such constructs as sexual incapacity, assumed etiologies, and acceptable therapeutic outcome.

Sexual Incapacity

Sexual incapacity cannot be measured by any objective or observable tests, scales, or examinations. The diagnosis must be made whenever a patient presents with a subjective complaint of failure to meet her/his[1] own and/or her partner's sexual-behavioral expectations. The problems about

which patients complain are most commonly one, more, or all of the five listed below:

1. Female—infrequent or complete absence of orgasms.

2. Male—impotence, the inability to obtain or maintain an erection.

3. Male—premature ejaculation, prior to or almost immediately after the penis is introduced into the vagina (Salzman, 1954).

4. Female and/or male—infrequent or complete lack of desire for sexual activity on the part of one or both partners.

5. Male and/or female—disgust, fear and/or anxiety at the thought of participating in sexual behavior.

These problems are frequently selective, being experienced primarily or exclusively only in sexual transactions:

1. With a specific person (spouse, fiancé, primary partner, etc.).

2. With a specific class of relationships (i.e., marital partner only, pickups only, obese partners only, nice girls only, etc.).

3. In specific places (i.e., in automobiles, on a beach, in the living room, in the bed, etc.).

4. Under specific conditions (only when drinking, only when fatigued, only when angry, only when playing a passive role, etc.).

The problems may be partial, complete, sporadic, or total and of long or short duration. Typically, once an individual experiences a sexual-response problem, she begins to predict the problem will recur every time a sexual response is desired or required. This fear that failure in sexual response will occur becomes as incapacitating as the inadequate response itself. The isolated, partial, or sporadic symptoms typically increase in frequency and severity with time unless the patient is given prompt, adequate reassurance, education, or the needed therapy.

The above description may seem too constraining to some readers. It is operational for this article only. It does not address itself to such questions as: (a) Is monogamy or having multiple partners the biological norm for human sexual transactions? (b) Should we utilize a descriptive (i.e., telling it like it is) or a prescriptive (i.e., telling it like it ought to be) norm to measure human sexual behavior? (c) Are love and/or legal sanction (marriage) an essential part of adequate sexual response? (d) Is homosexuality a life style or a sexual maladjustment needing therapy? (e) What about wife swapping, swinging, incest, masturbation, sadomasochistic sex, transvestism, transsexualism, etc.? These are not trivial issues on the contemporary human sexual scene, but are more philosophical than therapeutic at this time in human history (Marmour, 1971).

Etiology

Predominantly, patients complain of *their* behavioral failures to meet *their* own expectations for adequate sexual performance and enjoyment (Gutheil, 1959; Peterson, 1961; Wahl, 1967). Patients are problem- not diagnosis- oriented. They hurt and they seek to be relieved rather than classified and labeled. Wershub (1959) reports that approximately 5 percent of all sexual-inadequacy complaints have an etiology that is, in part or totally, related to structural, biochemical, and/or physiological disorders. These physical problems should be competently investigated whenever there is good reason to suspect their presence. Listed below are some of the more common structural, biochemical, and physiological causes of human sexual incapacity (Hastings, 1963):

Male (Wershub, 1959):

1. neurological lesions (Wershub, 1959)

    a) destruction and/or transection of the sacral spinal cord and the cauda equina and parasympathetic plexuses

    b) high lumbar sympathectomy when ganglions below the twelfth dorsal nerve on both sides are removed

2. diabetes Mellitus (Chokyu, 1965; Wershub, 1959)

3. Alcoholism (Levine, 1955)

4. drug addictions (narcotic, amphetamines [Bell, 1961; Wershub,

1959])

5. heavy-metal poisoning

6. peyronie's disease

7. lerichie's syndrome

8. calcification of the vas deferens (frequently diabetic also)

9. frolich's syndrome

10. phimosis

11. hydrocoele

12. varicocoele

13. crytorchidism

14. orchialgia

15. priapism

16. elephantiasis

17. sebaceous cysts scrotum

18. prostatectomy

19. perineal trauma

20. congenital anomalies (absent, concealed, adherent or double penis, hypospadias, episadias, anorchidism, sexual infantilism)

21. transsexual surgery

22. climacteric (Browning, 1960; Wershub, 1959)

23. aging

Female (Roen, 1968):

1. congenital defects (absent or infantile vagina or clitoris)

2. perineal trauma

3. pubococcygeus muscle relaxations and lacerations (Kegel, 1952; Roen, 1968)

4. clitoral adhesions (Clark, 1968; Roen, 1968)

5. atrophic changes after menopause

6. painful infections of vagina

7. pelvic inflammatory disease

8. cysts of labia

9. massive or painful tumors of the genitalia

10. painful rectal disease.

Routine investigation of each of the above in every patient presenting with a chief complaint of sexual inadequacy is an expensive and inconvenient disservice to the patient. The yield is low and the patient with the diseases listed above usually presents first with symptoms of his primary disease. The patient suffering only from a behavioral, sexual- inadequacy problem can become conditioned, by an overzealous search, to believe that there is some remote, as yet undiscovered, structural-biochemical-physiological problem that accounts for his sexual incapacity. Until this nonexistent physical condition is discovered, he refuses the treatment that can successfully influence his problem.

Overwhelmingly, human sexual-incapacity problems that are presented by patients are the consequences of: (1.) faulty learning; (2.) inadequate knowledge; (3.) inexperience; or (4.) anxiety. Only a therapy program addressing itself to these defects has any chance of consistent success.

American child-rearing patterns are eminently suited to the development of sexual-incapacity symptoms. The adolescent female is taught to attract males, exhibit sexiness, and participate in sexually arousing petting, up to a point. She is further taught that it is her job to "cool it" when she experiences a high level of excitement because he won't stop unless she does. When she learns her lesson perfectly, she grows up to be a non-orgasmic

woman. Her complaint is expressed as "I get very excited sexually, but when I feel like I am almost there, I just go numb and lose all my sexual feeling."

The adolescent male is warned not to get caught in the act, by catching VD or by impregnating a nice girl. It is implied simultaneously that he is lacking in masculinity if he doesn't seduce a few females. He cannot be caught if he is unable to have an erection, and is less likely to be caught if he only has a "quickie." Anxiety about being caught on the one hand, and fear of not performing like a stud on the other set the stage for the male symptoms of prematurity and impotence.

Since sexual-incapacity symptoms so frequently are specifically related to the sexual interaction between the presenting patient and her primary partner, most successful therapy programs focus on the therapy of both sexual partners and their relationship rather than attempting to treat only the individual who initially complains (Masters, 1970). At times partners' complaints appear to be reciprocal; as one improves, symptoms appear in the other unless both are in a therapy program together. Brody's successful treatment of 65 percent of 105 females without treating their partners is a notable exception (Brody, 1972).

Acceptable Therapeutic Outcome

The only acceptable therapeutic outcome is one in which the patient's

behavior has changed in the direction of her own stated expectations. The patient initially needs help in explicitly defining her own sexual expectations. Occasionally, she needs help in modifying her expectations into some that are more realistic than those which she brought with her to the therapist. "Insight" without behavioral change cannot be considered an acceptable outcome of sex therapy. Insight with behavioral change is attractive, but is probably of insignificant value to the patient. Knowing why and being able to construct an interrelated etiological-therapeutic model is very important to the researcher. Knowing how to cause a lasting change in the incapacitating behavior is more important to the therapist. The therapist's primary responsibility is to help her patient attain a therapeutic result acceptable to the patient. Sex therapists must decide, before starting with their patients, whether they are primarily therapists or primarily researchers. By first setting up measurable relevant objectives against which the therapeutic outcomes will be measured, therapists can contribute to their own and others knowledge. Having an attractive, internally consistent, abstract model, designing a therapy to fit the model, and explaining away unsuccessful therapeutic outcomes contributes nothing.

Examination of the Sexually Incapacitated Patient

History Taking

Diagnosis and treatment are more dependent on the patient's history (Hastings, 1963; Masters, 1970) than the physical or laboratory findings. Therefore, a detailed problem-oriented story of the way in which the patient's sexual behavior doesn't meet her expectations is essential. However, obtaining the needed history doesn't require any special techniques or outlines. The data should describe the symptoms, their frequency and duration, their consistency, the specific circumstances or factors under which symptoms occur, vary, or are absent. It is also important to know whether the symptoms occur with all partners and with all forms of stimulation (genital, oral, manual, self-induced as well as partner induced). If the patient has had any therapy, the type, duration, and outcome should be documented. None of this data base is different from the kinds of data appropriately collected on any medical problem.

Since therapists are trying to change the behavior of their patients, the more a therapist learns about her patients' life styles, personal traits and habits, problem-solving patterns, anxiety levels, life goals, ambitions, values, and fantasies, the better. It is usually valuable to have a gestalt of a patient's total behavioral functioning, but this is especially important when the therapeutic goal is to change behavior.

Eliciting the history is more dependent on a therapist's comfort with human sexuality and her breadth of knowledge about the wide range of

human sexual behavior than on any special interviewing techniques or gimmicks (Lash, 1968; Tunnadine, 1970; Tyler, 1968).

Physical Examination

A general physical examination with thorough observation of the genital anatomy is indicated routinely. The examiner is looking for congenital defects, scarring, local infections, degenerative changes, and unusual size. It is perfectly acceptable for the sex therapists to do their own physical examination within the limits of their competence (Hartman, 1970).

When a specific organic disease from the above etiological list is suspected, appropriate physical examinations, and laboratory and x- ray studies must be included. Consultations should be requested when these examinations are beyond the sex therapist's level of competence in the diagnosis and/or management of these diseases.

Specific Therapeutic Goals

Regardless of the therapy strategy or procedures one utilizes, it appears that there are three specific goals. They can be met by any of the following commonly used techniques: (1) reducing anxiety; (2) extinguishing old incapacitating sexual behavior patterns; and (3) conditioning to respond to biological sensual cues (Hartman, 1970; Kegel, 1952; Pullias, 1937).

1. Before attempting anything else, the therapist must reduce the amount of anxiety that the patient feels about her past and current sexual behavior, performance, and attitudes. It is the author's opinion that the patient usually experiences this sexual anxiety in two forms: shame-and-guilt anxiety, and performance anxiety. Shame-and-guilt anxiety is more commonly seen in persons who had rigid moral or religious upbringing, who are compulsive, who have a general discomfort with messy or "dirty" activities and are uncomfortable with physical and emotional intimacy (e.g., touching another individual). Performance anxiety is more likely to be found in persons who are competitive, ambitious, physically perfectionistic, and intellectually sharp. A combination of both is seen in persons who try to reduce shame and guilt by turning any performance into work. They believe it's acceptable to participate in pleasurable activities as long as one really works at it.

Tranquilizing drugs (Freyhan, 1961; Greenberg, 1965; Haider, 1966) are not the therapy of choice in managing these sexual anxieties. A more effective strategy is a therapy based on the principle that therapists are authority figures and members of the "establishment" who have more humanistic and permissive attitudes on sexuality than the patients have encountered in their past. These authority figures are open to and not fearful of their patients' sexuality. These less fearful and more permissive authoritative figures convey in gesture, manner, tone of voice, and content

that it is okay, it is normal and it is not immoral to have sexual feelings, sexual thoughts, and sexual desires. They approve open, honest inquiry and communication about sexual matters between the patient and themselves, patient and friends, patient and potential sexual partners. They encourage the patient to explore and define her sexual expectations. They are not alarmed or judgmental when the patient's desires, expectations, and moral values appear to be in conflict. The patient's anxiety about her sexual behavior, desires, and attitudes is far more effectively reduced by the therapist's gestalt of overall comfort and tolerance about human sexuality than by a relatively uninvolved or even apprehensive exploration of the patient's past as practiced by many traditional psychotherapists.

2. Old patterns of sexual behavior that have not worked in the past need to be extinguished to make the patient more receptive to learning new, more effective patterns. As long as the older, familiar patterns are still available, one tends to repeat them even when these are relatively unsatisfactory. This is particularly true when the patient feels anxious and/or there are no visible alternative patterns of sexual behavior. The initial goal was to reduce anxiety. The reduction of anxiety makes it easier for the patient to avoid returning to her old patterns. Not using the old unsatisfactory pattern reduces the anxiety even more, and both make the patient more receptive to learning new patterns not visible or attainable in the past. Interference with the patient's continued use of her old patterns creates a vacuum and helps to motivate the

learning of new acceptable substitutes that evoke less anxiety and incapacity. An effective way to interrupt the older patterns is to make a "contract" with one's patients that, while undergoing therapy, they will refrain from any sexual activity other than that discussed with and prescribed by the therapist. Masters and Johnson (1970) simply inform their patients that they are not to have any intercourse until the therapists believe they are ready. It is obvious that both the patients and their therapists must have a great deal of confidence in the therapist's ability if they are to agree to such a "contract" as no intercourse until it is prescribed by the therapist.

3. Conditioning the patient to listen to (i.e., pay attention to and respond to) her own human, biological-sensual cues is the final step. Most patients who are performing sexually in a way that does not meet their own expectations find themselves trying to will an orgasm, erection, or sexual desire. They substitute conscious cortical control for a spontaneous response to proprioceptive-sensory input from the sensual areas of their own bodies. In contemporary society we have discouraged physical exploration of one's own body and tender (as distinguished from competitive and/or violent) physical contact with each other. This has encouraged using cerebration and fantasy to deal with stimuli, desires, and temptations that are taboo. Many modern humans have learned to suppress their biological-sensual cues. Since this inhibition is a taught and learned phenomenon, it can be unlearned. To improve sexually the patient must be taught to listen and respond to her

genital, sensual, proprioceptive information and not permit this input to be overruled by "logical," "rational," cortical controls (Masters, 1970). Lidz says (1968):

> The proper carrying out of the sexual act and the enjoyment of it involves an ability to give way to the irrational, the timeless, the purely animal in one: it includes a loss of individuality in a temporary fusion with another. It contains the potentiality of leaving behind the tensions of civilization as one loosens the bonds to reality to float again in the purely sensuous. Here, one needs to be unabashed by the nakedness of impulse and drive, by recrudescence of the infantile and the revealing of much that one has sought to hide from others. The woman in particular requires a capacity to rescind control and give way before an ecstasy that threatens to overwhelm and annihilate her by its very intensity. The sexual act contains a definite and direct relationship to infantile relatedness to the mother, with a renewed interest in sucking, in odor, in skin eroticism; and a reawakening of old forbidden desires to explore and play with orifices. So very much that has been learned needs to be undone; much that has been hidden and long repressed and kept unconscious but that haunted dreams and masturbatory fantasies needs to be released to permit sexual intimacy and enjoyment and to allow fulfillment rather than provoke shame and guilt. The very good sexual adjustment demands such abilities to reverse the socialization process—and yet to permit the individual to be secure in the feeling that the regression and reversal will only be temporary and not reclaim the self. [p. 424]

The therapeutic strategy can now be seen as a combination of: (1) reducing the patient's guilt and performance anxiety by authoritative permissiveness, education and reassurance; (2) reducing the anxiety still further by interfering with the old patterns that originally had been shaped by the anxiety and ultimately became a source of anxiety as well; (3) creating

a temporary vacuum to stimulate motivation for learning new patterns, and (4) teaching the patient to respond more spontaneously to her own biological-sensual stimuli.

Low anxiety is optimal for predictable learning. One learns during a state of high anxiety, but what will be learned is less under the control of the teacher (i.e., therapist). When the new patterns to be learned are offered in such a graduated form that the patient never experiences a rapid rise in anxiety and experiences a small but constant measure of success, what is learned not only increases the patient's competence but reduces the reappearance of performance anxiety. In both behavior therapy (Lazarus, 1969) and Masters and Johnson sex therapy(Masters, 1970), attention is given to introducing small but graduated changes, starting in areas the therapist predicts are unlikely to evoke anxiety. Progression is paced, to continue to hold anxiety to a minimum, as the patient is encouraged to move closer and closer to functioning sexually in a biologically natural way.

Therapeutic Techniques

At the present time, sexual-incapacity-therapy regimes, strategies, techniques, and gimmicks are almost as numerous as the number of therapists (Cooper, 1969; Diamond, 1968; Faulk, 1971; Klemer, 1965; Wahl, 1967). Most therapists identify themselves as using some specific technique

described by a well-known therapist. However, most of these are self-trained. Typically, they use an ill- defined blend of their own psychotherapeutic skills with things they have read or heard that other therapists utilize in sex therapy. Too few keep records suitable for audit or reporting in the literature. Most devote only a small percentage of their time to sex therapy, and so any given patient is likely to find herself being shifted back and forth from sex therapy to marital counseling to individual psychotherapy.

Therapists carefully trained in behavior therapy have applied these simple, behavior- modification techniques to the complex of behaviors involved in human sexual interactions (Dengrove, 1967; Haslam, 1965; Holroyd, 1970; Jones, 1972; Kraft, 1967). Both behavior-modification therapists and Masters and Johnson oriented therapists have the overall objective of producing a change in the patient's sexual behavior. There are differences in their strategies, techniques, and theoretical models. The other large group, psychodynamic psychotherapists, accept insight and understanding as a major objective (Hummer, 1966). They, therefore, use significantly different strategies and techniques. Another strategy is the use of mechanical devices [Russel, 1959] (such as vibrators, penile splints, artificial vaginas, etc. [Lowenstein, 1941]), pharmaceutical agents (hormones [Andersen, 1958; Borelli, 1967; Margolis, 1966; Seid, 1962], vitamin E, psychotropic agents [Kiev, 1968], anesthetic ointments), dietary fads (raw oysters, raw eggs, wheat germ, etc.) and surgical procedures (Deutsch, 1965;

Lash, 1968; Lydston, 1908; Pearman, 1972). These are used independently or in combination with other therapies. Even direct personal instruction via coitus with the therapists has been recommended.

Variables Influencing Outcome

It now appears that a wide variety of therapeutic strategies and procedures utilized have been influential or coincidental with favorable outcomes. However, serious evaluation of the efficacy of these various therapeutic efforts has been difficult. No well-defined criteria have been established to determine something as simple but essential as how to differentiate between severe cases needing intensive, skilled therapy and mild cases that might have resolved spontaneously or with brief reassurance and accurate information from minimally skilled, warm, tolerant humans with some professional status and credibility. It is the author's observation that choosing a particular procedure seems less important than the therapist's belief that she knows what she is doing will work (Tyler, 1968).

Another significant variable is how much suffering the patient is experiencing from her sexual incapacity problems at the time she seeks therapy. It seems more logical, as well as humane, to conceptualize this as the level of positive motivation toward relief rather than a resistance against change. Oversimplified, the question is whether the patient hurts enough to

seek out a therapist who is confident, available, and affordable, and to trust this therapist enough to allow her sexual behavior to be shaped. Additionally, since therapy is directed at the sexual partners, both must be at a similar level of motivation at the same time.

The personality of the therapist is frequently stated to be a crucial factor in any therapeutic procedure. Psychiatric resident applicants are frequently evaluated, sometimes elaborately, in an effort to screen *out* those believed to be poorly qualified. The specific behavioral objectives of residency training for which they are found unqualified is not usually spelled out.

More rarely are evaluations conducted with the goal of "screening in" those with specific characteristics desirable in a therapist. Screening in is very important in both self-selection and training-program selection for sex therapists.

Without presuming to set *the* inclusive criteria, it is useful to describe the characteristics observed in a variety of therapists who devote a significant amount of their time treating sexual incapacities.

1. They are careful listeners.

2. They are persistent history takers.

3. They are more problem-oriented than diagnosis-oriented.

4. They help patients conceptualize and define their own sexual expectations.

5. They do not push their own values on their patients as better, healthier, or more "normal" (Tyler, 1973).

6. They are aware of and tolerant of a wide range of human sexual behavior.

7. They openly convey warmth, concern for, interest and involvement in, their patients' sexual discomforts and disabilities.

8. They do not hesitate to be firm, directive, and authoritative (not authoritarian).

9. They experiment—i.e., do what "feels right" at the moment.

10. They pay close attention to immediate feedback and modify their techniques, strategies, and communications immediately, as the feedback indicates.

It is worth repeating that this list does not pretend to be a complete or prescriptive guide for selecting sex therapists. It is a description of those characteristics common to several sex therapists who have some consistent degree of success in their sex-therapy practices.

Behavior Therapy

The specific techniques of behavior-modification therapy are

adequately described in Chapter 15 of this volume and will not be repeated here. The same basic techniques are applied to changing the unacceptable sexual behavior (Dengrove, 1967; Haslam, 1965; Holroyd, 1970; Jones, 1972; Kraft, 1967; Lazarus, 1963). A given therapist may elect to use some of the "sensate-focus" exercises used by the Masters and Johnson disciples, and/or the role-playing, confrontation techniques used by encounter-group leaders.

Psychotherapy

The strategies and techniques used in psychotherapy are adequately described elsewhere in this volume. These are less homogeneous than the behavior therapies. These are also likely to be applied unmodified to the patient's sexual problems. The amount of emphasis on the patients' understanding of their basic psychological problems, "working through" of their conflicts and accepting the therapists' theoretical premises (Spiegal, 1967), is highly variable from therapist to therapist. The therapist's comfort with human sexual behavior and her definition of what is "normal" are much more critical factors in psychodynamic psychotherapy than they are to the more ritualized behavior therapies (Marmour, 1971). A given psychotherapist may selectively introduce some of the sensate-focus exercises (Masters, 1970) and encounter-group techniques but, as a rule, is less comfortable with these. Psychotherapists have usually been indoctrinated to be nondirective, unrevealing of how they feel or what they

are experiencing, and not to touch their patients. It is difficult to prescribe sensate-focus exercises or to utilize encounter-group techniques without directing, revealing, or touching. When therapists do not routinely use these in their clinical practices, they are initially unsure and hesitant when introducing them in sex therapy. The end result is that they remain uncomfortable as sex therapists or begin to introduce similar techniques in their therapy of other patients. This is usually good if they are comfortable and open about these modifications of their therapy techniques. It is usually bad when they feel guilt about "betraying" their teachers and the theories on which their previous therapeutic techniques have been based.

Hypnosis (Mirowitz, 1966)

Hypnotic therapy is discussed in Chapter 12 of this volume. These techniques are also applied directly to sexual-incapacity symptoms by suggesting relaxation and loss of inhibition in responding to sexual arousal. Hypnosis may be used independently or in combination with any of the other therapies discussed in this chapter.

The Masters and Johnson Approach

Masters and Johnson have developed a human, sexual-inadequacy therapy (1970) that has popularized a broad awareness of the problem and

has offered the most consistent therapeutic success. This "sensate-focus" approach is presently the therapy of choice among the majority of practitioners who deal with sexual incapacity problems and as such deserves a more detailed presentation.

Sensate-Focus-Oriented Therapy

The basic concept of sensate-focus-oriented therapy is that the person with sexual problems is not paying attention to and responding to her own natural, biological-sensual cues. Therapy is directed toward freeing the patient to become capable of experiencing the pleasurable and exciting sensory stimuli from her genital anatomy. When this is accomplished, it is believed that these formerly sexually incapacited persons will be permanently able to experience and respond to their own sexual needs without incapacitating symptoms.

A few sex therapists have been trained by Masters and Johnson, but most sensate-focus sex therapists use their own version of the technique. Although variations do exist in the details of the therapeutic attack as employed by different therapists, the similarities are sufficiently widespread to warrant an attempt to extract the basic principles upon which the therapeutic strategies and techniques are based.

Most therapists focus on the therapy of a *sexual unit* rather than an

individual. A sexual unit may be defined as a married couple, an engaged couple, or an individual and her primary sexual partner. Masters and Johnson reported on the use of successful surrogate partners when no natural primary partner was available. Therapy is usually conducted in joint interviews with both partners always present.

Coequal male-female co-therapy teams are said to be the ideal model (Masters, 1970). Unless the therapists are equal in each other's and their patients' eyes, male and female co-therapists add little except cost. Too often a chauvinistic male therapist brings any female he can find into the therapy session and appoints her to be his "cotherapist." She has little background to understand what is taking place, little or no status in either the patients' or the male therapist's eyes and presents a model of male- female inequality to the patient couple. Even two equal co-therapists have to work at presenting themselves as a team not dominated by either the male or the female. This is most likely to occur when each is comfortable with her or his own and each other's sexuality. Verbal encountering to clarify their interpersonal relationship with each other is often helpful.

Therapy typically starts with a long detailed *history* (Hastings, 1963; Masters, 1970). This serves three purposes: (1) establishing communication; (2) understanding most of the patients' sexual patterns of behavior, attitudes, needs, fantasies, and expectations; and (3) exposing the therapists' sexual

attitudes and tolerance level to the patients.

Following this a *contract* is negotiated (Masters, 1970). The therapists share their understanding of the problem with the patients and a therapeutic plan is agreed upon. In addition to cost, duration, and appointment frequency the "contract" includes such items as: availability of therapists beyond the regularly scheduled appointments, how much control of the patients' sexual behavior by the therapists will be required, how much homework is indicated, whether therapy will be limited to sexual behavior or also include counseling about other personal, interpersonal, and marital problems.

Reassurance and support, which have been developing, are now more strongly reinforced. The overall message conveyed is, "I, your therapist, do understand your sexual problems, accept where you are, and am willing and able to help you. I am an authority figure who is more knowledgeable, understanding, and permissive of your sexuality than other authority figures you have known in your past. You are human beings with your own sexual expectations, which I now understand and will respect."

Effective communication skills between the sexual partners have usually deteriorated and therapy moves along more smoothly when therapists focus on this problem early (Lederer, 1968; O'Neil, 1972). Effective communication may be verbal, para- verbal, or nonverbal, but is always characterized by

messages that are equally clear to the sender and the receiver. Sexual communications are most clear when they deal with the "here and now" rather than the past or the future, are statements concerning "where I am," "what I am experiencing," inquire rather than accuse, assume, predict, or guess the partner's motives, wishes, or needs, and are not distortions of reality. The therapist may choose to end the first session with the patient couple by inviting them to try this style of communication for a week before proceeding to work on the sexual behavior itself. Most couples who agree to try this have been moderately successful. They report a reduction in their hostility, their anxiety, and their misunderstanding of each other's messages.

Estimation of motivation for change is necessary. This is less important in the two-week concentrated program offered by Masters and Johnson than in the variations that employ one or two appointments weekly. The latter strategy is quite dependent on the patients' willingness to spend time doing the prescribed homework. When the couple can't find time for thirty minutes of uninterrupted sensate- focus exercises at least every other night, therapy should be discontinued until the patients can arrange their schedules.

Availability by phone is desirable when the therapists choose a once or twice weekly interview strategy. It is the author's experience that the phone-call availability is rarely abused. Mandatory delay of feedback until the next scheduled appointment allows a bad situation to get worse and slows down

progress when things are going well.

The *homework* is a sine qua non for successful sex therapy (Masters, 1970). It consists of carefully prescribed, reciprocating body-massage exercises. The couple is instructed to spend an uninterrupted thirty to forty-five minutes on this activity at least every other night. They take turns at "pleasuring" and "being pleasured by" each other. The primary objective is for each to develop her or his own sensate-focus awareness without moving ahead fast enough to develop incapacitating anxiety. Additionally, each has an opportunity to learn that pleasuring can be as exciting as being pleasured (Masters, 1970).

The couple is instructed to lie nude beside each other on a bed in a lighted room and relax. When they feel somewhat relaxed, pleasuring starts with gentle massaging of non-eroticized areas of the receiver's body. By random selection one has been assigned the role of giver only and the other of receiver only. Halfway through the exercises they will change roles. It is felt that initially concentrating on only one role maximizes awareness and proficiency in that role. Much later blending of the two roles alternately or simultaneously will be a matter of personal preference.

The giver is in charge of what is given as long as pressure is not put on the receiver to respond with anything other than what the receiver is

spontaneously experiencing. The goal is to develop an awareness of experiencing the sensory stimuli generated from one's own body being touched and from touching one's partner's body (Hollender, 1969). Premature demand for sexual performance either from oneself or one's partner evokes anxiety and interferes with learning to pay attention to one's own pleasurable sensory cues.

A few nights to a week later the receiver is allowed to indicate preferences in the kind and location of the massaging that is preferred. This is a learning exercise in which the patients teach one another what they have learned about themselves while in the receiving role. Each also learns what pleases the other, and the importance of keeping each other informed. When they do not aggressively make specific demands, both become less fearful of being neglected or of being overwhelmed by the demands of the partner.

Many sexually incapacitated persons do not like to touch "messy," "dirty," "sticky," "slimy," substances, i.e., normal vaginal secretions or semen. Therefore, at this stage, hand lotion is introduced in the massaging exercises (Masters, 1970). Any "clean," "sterile," water-soluble hand lotion will suffice. It should be used in sufficient quantities as to be experienced as "messy" but paired with the already pleasurable sensation of being massaged.

Next the constraint of limiting the massages to non-eroticized areas of

the partner's body is removed. This is prescribed when the therapists believe the couple can experience sensual arousal without significant anxiety. Now the goal becomes developing awareness of sensual stimuli originating in one's body rather than that originating primarily in one's head (Kegel, 1952; Masters, 1970). This may be a particularly difficult phase for the less incapacitated partner if she or he is highly aroused sexually but constrained from having sex relations because of an earlier contract with the therapists. The couple is reassured that a spontaneous orgasm is acceptable, but pressuring oneself or one's partner is not. Since the receiver can control how much stimulation she or he accepts and the giver can decide how much she or he is willing to offer, the chance for making anxiety provoking demands is minimized. Independently, or with the help of the therapists, the couple may negotiate to allow the over-aroused individual to masturbate for relief.

When the couple is sufficiently comfortable with experiencing sensual arousal, they are permissively encouraged to experiment with experiencing a full sexual response, dependent primarily on body, not head, stimulation (Masters, 1970). Initially, this should be experienced by one in the receiver role only. Manual stimulation for this first full sexual turn on is least likely to tempt the previously incapacitated person to return to the older unsatisfactory sexual patterns. However, the therapists must use their clinical judgment about when to prohibit, permit, or encourage oral-genital or genital-genital stimulation. In either case, the previously sexually

incapacitated person should be allowed to satisfy herself before trying to satisfy her partner. Learning how to recognize, sort out, and spontaneously respond to sensual body stimuli is necessary before one can effectively participate in simultaneously giving and receiving sexual responses.

After both partners are able to experience desire, arousal, pleasurable excitement, and orgasm when in a receiver role only, the constraint on intercourse is removed. The therapists should help the couple select a time, place, and set of circumstances least likely to evoke anxiety or fear of failure. The couple must be reassured that lack of complete success at this point doesn't mean starting all over again. It is helpful to supportively remind them how far they have already come. Anything that reduces the anxiety of the couple seeing this as the "final exam" is helpful. Demanding good performance of themselves or each other now will have the same counterproductive effect it had in the past.

A failure, even after weeks or months of satisfactory sexual performance, may panic one or both partners into making a self-fulfilling prophesy of a return of the old sexual incapacity.

Interviews, during the sensate-focus homework exercises, are used to explore, clarify, instruct, educate, reassure, praise, support, and maintain the patients' enthusiasm. Primarily, discussions focus on sexual behavior, but,

from time to time, exploring some other aspect of the couple's interpersonal relationship may facilitate their ability to interact sexually. Nonverbal encounter-group techniques and role playing can be effective in helping the couple recognize and/or express themselves when verbal communication becomes garbled or blocked. However, therapists who are themselves uncomfortable when interacting with their patients nonverbally will find it difficult to convince their patients to participate.

Sex education is valuable for some patients who have very limited information and very little ingenuity. When they become free enough to experiment, they have no models or guidelines. Reassuring information, reading materials, pictures, models, and movies can be used to stimulate discussion. These are offered permissively and as possible patterns the patients may want to consider for themselves. Setting up a competitive situation must be actively avoided.

When the primary symptom is *premature ejaculation* rather than male impotence or a non-orgasmic female, an addition to the above techniques is indicated. Medication (Gibbons, 1923), hypnosis, and psychotherapy have been used, but techniques specific for the symptom (Ahmed, 1968, Masters, 1970) offer more consistent success. The best-known technique was described by Semans (1956) and is called the Semans squeeze technique. Vandervoort (1972) has published an illustrated booklet describing its use.

Oversimplified, the male recognizes his pre-ejaculatory inevitability and informs his partner. She grasps the head of his penis between her thumb and fingers hard enough to hurt. His urge to ejaculate and some of his erection disappear. Sexual activity is resumed and the steps above repeated as frequently as necessary. Over time, the male is conditioned to last longer before ejaculation.

A more humane approach also involves the active, willing cooperation of the partner (Hirsh, 1951). She lightly strokes the penis until he experiences prejaculatory inevitability. He indicates this state, and she stops. A minute or two later when the inevitability feeling has passed, she resumes stroking the penis and the process is repeated several times. Masters and Johnson report that this technique can increase duration after intromission from a few seconds to several minutes. The strategy is to increase the male's tolerance for experiencing genital stimulation without adding to his mental excitement and anxieties. Most males spontaneously prescribe the reverse of this for themselves trying to avoid all stimulation until the moment of vaginal entry. This means relying primarily on intellectual and fantasy stimulation to obtain and maintain their erections.

Conclusions

The therapy of human sexual incapacities is a mixed bag at the time of

this writing. The syndromes of sexual problems are ill-defined and vague or operationally defined and arbitrary. The "diagnostic" categories are not well related to specific etiologies, pathologies, prognoses, or therapeutic regimes. Therapies are loosely structured, vary from therapist to therapist, and the model, principles, or strategies are rarely identified. Treatment is most likely to be aimed either at specific symptoms or at overall improvement in the patients' psychological adjustment.

On the positive side, human sexual functioning has become a legitimate concern of those offering health-care services. The newness and as yet poorly defined diagnostic categories make this group of human maladies more patient-oriented than is the case in more traditional medical care. It is accepted that sexual incapacity can only be diagnosed subjectively by the patient herself. This potentially gives the patient options in deciding how much and what treatments she will accept, since the patient defines her own incapacity in terms of a variance from her personal expectations for her own sexual health. In offering the patients these kinds of "diagnosis" and "therapy" options, human sexual health care is more advanced than other areas of health care.

Preventive measures are still poorly understood. The role of sex education in prevention of sexual-inadequacy problems is still very controversial (Vincent, 1968). The August 25, 1969, *AMA News* reported,

"When most of the emotion is stripped away, the basic views of the proponents and opponents of sexual education are these: the *former* hold that sex education courses are designed to answer the 'whys' of children's questions about family life, physiological development and its relationship to the society in which they live. It's taught in a clinical, detailed manner which allows students to make their own moral judgments. *Opponents* hold that sex education courses are really 'how to' courses that teach mechanics of intercourse without morals attached to it." Both are partly right. Courses *should he* designed and delivered to do what proponents aim for, but frequently they are so poorly *conceived* and/or *delivered* as to *accomplish* what the opponents claim. Even when the moral aspects are stripped away, hunch rather than data relates sex education to better sexual functioning.

Most sex therapists believe reassurance about the normality of sexual feelings plus accurate information about patterns, varieties, and frequencies of sexual behaviors, the existence of recreational as well as procreational sex, the relationships between sex, love, and marriage, the relationships between menstruation, menopause, old age, and sexual behavior should be readily available to all humans as they need it. Our current divorce rate and the frequency of sexual incapacities and marital discord suggest that a better preparation for sexual roles is needed before humans reach adulthood. When parents become comfortable with their own sexuality, their children can obtain most of the sex education they need from their own parents in their

own homes. Parents need to: (1) encourage their children to be curious about any and everything known to mankind; (2) offer their children a model of two adults who are involved, intimate, and not afraid to show affection for each other; and (3) help their children understand that it's okay to pursue pleasure as a positive goal rather than as something only experienced by breaking the rules.

Basically, this prescription assumes that young humans who are allowed to experience reality as it occurs become those best able to recognize and deal with reality as they grow older. Sexual functioning is a significant part of human reality. As humans become better able to deal with their sexual reality, the need for therapy of sexual incapacities will decrease.

Bibliography

Ahmed, S. H. "Treatment of Premature Ejaculation," *Br. J. Psychiatry,* 114 (1968), 1197-1198.

Andersen, A. P. "Androgenic Treatment of Frigidity," *Geburtshilfe. Frauenheilkd.,* 18 (1958), 632.

Bell, D. S. and W. H. Trethowan. "Amphetamine Addiction and Disturbed Sexuality," *Arch. Gen. Psychiatry,* 4 (1961), 74-78.

Borelli, S. "On the Prescription of Sex Hormones in Male Sex Disorder," *Landarzt,* 43 (1967), 476-477.

Brady, J. P. "Brevital-Relaxation Treatment of Fridigity," *Behav. Res. Ther.,* 4 (1966), 71-77.

Brody, H. "Sex Therapy of 105 Women Only—(Ongoing Research)," Personal Communication,

Calgary University, 1972.

Browning, W. J. "Male Climacteric and Impotence," *Int. Rec. Med.,* 173 (1960), 690-694.

Chokyu, K. "Studies on Diabetes Mellitus and Functions of the Male Sexual Glands," *Acta Urol. Jap.,* 11 (1965), 850-876.

Clark, L. "Frigidity," in *101 Intimate Sexual Problems Answered,* pp. 89-97. New York: Signet Books, 1968.

Condrau, G. "On the Psychotherapy of Male Impotence," *Praxis,* 49 (1960), 641-644.

Cooper, A. J. "Outpatient Treatment of Impotence," *J. Nerv. Ment. Dis.,* 149 (1969), 360-370.

Dengrove, E. "Behavior Therapy of the Sexual Disorders," *J. Sex Res.,* 3 (1967), 49-61.

Deutsch, H. "Frigidity in Women," in *Neurosis and Character Types.* New York: International Universities Press, 1965.

Diamond, M., ed. *Perspectives in Reproduction and Sexual Behavior.* Bloomington: Indiana University Press, 1968.

Ditman, K. S. "Inhibition of Ejaculation by Chlorprothixene," *Am. J. Psychiatry,* 120 (1964), 1004-1005.

Faulk, M. "Factors in the Treatment of Frigidity," *Br. J. Psychiatry,* 119 (1971), 53-56.

Ferenczi, S. "The Analytic Interpretation and Treatment of Psychosexual Impotence," in *Sex in Psychoanalysis.* New York: Dover, 1956.

Finkle, A. L. "Trauma and Sexual Impotence," *J. Trauma,* 4 (1962), 60-97.

Flick, L. "Evaluation of Female Orgastic Capacity and Its Disorders from the Psychoanalytic Point of View," *Psyche,* 23 (1969). 58-74.

Freud, S. (1931) "Female Sexuality," in J. Strachey, ed., *Standard Edition,* Vol. 21, pp. 223-243.

London: Hogarth, 1955.

Freyhan, F. A. "Loss of Ejaculation During Mellaril Treatment," *Am. J. Psychiatry,* 118 (1961), 171-172.

Gibbons, R. A. "Frigidity (Anaphrodisia)," in *Sterility in Woman,* pp. 167-172. London: Churchill, 1923.

Glen, J. and E. H. Kaplan. "Types of Orgasm in Women: A Critical Review and Redefinition," *J. Am. Psychoanal. Assoc.,* 16 (1968), 549-564.

Greenberg, H. R. "Erectile Impotence during the Course of Tofranil Therapy," *Am. J. Psychiatry,* 121 (1965), 1021.

Gutheil, E. H. "Sexual Dysfunctions in Men," in S. Arieti, ed., *American Handbook of Psychiatry,* Vol. 1, 1st ed., pp. 708- 726. New York: Basic Books, 1959.

Haider, I. "Thiodiazine and Sexual Dysfunctions," *Int. J. Neuropsychiatry,* 2 (1966), 255-257.

Hartman, W. and M. Fithian. *Nudist Society.* New York: Crown, 1970.

Haslam, M. T. "The Treatment of Psychogenic Dyspareunia by Reciprocal Inhibition," *Br. J. Psychiatry,* 111 (1965), 280- 282.

Hastings, D. W. *Impotence and Frigidity.* Boston: Little, Brown, 1963.

Hirsh, E. W. "The Role of the Female Partner in Premature Ejaculation," *Int. J. Sexol.,* 5 (1951), 1-6.

Hollender, M. H., L. Luborsky, and J. J. Scaramella. "Body Contact and Sexual Enticement," *Arch. Gen. Psychiatry,* 20 (1969), 188-191.

Holroyd, J. "Treatment of a Married Virgin by Behavior Therapy," *Obstet. Gynecol.,* 36 (1970), 469-472.

Hummer, W. K. "Frigidity in Women: A Symptom not a Diagnosis," *Minn. Med.,* 49 (1966), 1879-1884.

Johnson, J. *Disorders of Sexual Potency in the Male.* Oxford: Pergamon, 1968.

Jones, W. and P. Park. "Treatment of Single Partner Sexual Dysfunction by Systematic Desensitization," *Obstet. Gynecol.,* 39 (1972), 411-417.

Kegel, A. H. "Sexual Functions of the Pubococcygeneus Muscle," *West. J. Surg. Obstet. Gynecol.,* 6 (1952), 521.

Kiev, A. and E. Hackett. "The Chemotherapy of Impotence and Frigidity," *J. Sex Res.,* 4 (1968), 220-224.

Klemer, R. H., ed. "Counseling in Sexual Problems," in *Counseling in Marital and Sexual Problems,* pp. 92-186. Baltimore: Williams & Wilkins, 1965.

Kraft, T. and I. Al-Issa. "Behavior Therapy in the Treatment of Frigidity," *Am. J. Psychother.,* 21 (1967), 116-120.

Lash, H. "Silicone Implant for Impotence," *J. Urol.,* 100 (1968), 709-710.

Lazarus, A. A. "The Treatment of Chronic Frigidity by Systematic Desensitization," *J. Nerv. Ment. Dis.,* 136 (1963), 272-278.

----. "Modes of Treatment for Sexual Inadequacies," *Med. Asp. Hum. Sexual.,* 3 (1969). 53-58.

Lederer, W. and D. Jackson. *The Mirages of Marriage.* New York: Norton, 1968.

Levine, J. "The Sexual Adjustment of Alcoholics," *Q. J. Stud. Alcohol,* 16 (1955), 675-680.

Lidz, T. *The Person.* New York: Basic Books, 1968.

Lowenstein, J. "Treatment of Impotence: A Coitus-Training Apparatus," *Br. Med. J.,* 2 (1941), 49-50.

Lydston, G. F. "Surgical Treatment of Impotence," *Am. J. Clin. Med.,* 15 (1908), 1571.

Margolis, R. and C. H. Leslie. "Review of Studies on a Mixture of Nux Vomica, Yohimbine and

Methyl Testosterone in the Treatment of Impotence," *Curr. Ther. Res.,* 8 (1966), 280-284.

Marmour, J. "Normal and Deviant Sexual Behavior," *JAMA,* 217 (1971), 165-170.

Masters, W. and V. Johnson. *Human Sexual Response.* Boston: Little, Brown, 1968.

----. *Human Sexual Inadequacy.* Boston: Little, Brown, 1970.

Mirowitz, J. M. "The Utilization of Hypnosis in Psychic Impotence," *Br. J. Med. Hypn.,* 17 (1966), 25-32.

Moore, B. E. "Frigidity: A Review of Psychoanalytic Literature," *Psychoanal. Q.,* 33 (1964), 323-349.

O'Neil, N. and G. O'Neil. *Open Marriage,* New York: Evans, 1972.

Pearman, R. "Insertion of a Silastic Penile Prosthesis for the Treatment of Organic Sexual Impotence," *J. Urol.,* 107 (1972), 802-806.

Peterson, J. A. "Emotional Factors in Infertility," in E. T. Tyler, ed., *Sterility—Office Management of the Infertile Couple,* pp. 282-299. New York: McGraw-Hill, 1961.

Pullias, E. V. "Masturbation as a Mental Hygiene Problem: A Study of the Beliefs of 75 Young Men," *J. Abnorm. Psychol.,* 32 (1937), 216-222.

Rachman, S. "Sexual Disorders and Behavior Therapy," *Am. J. Psychiatry,* 118 (1961), 235-240.

Roen, P. R. "Urologic Causes of Frigidity," *Med. Asp. Hum. Sexual.,* 2 (1968), 20-21.

Russel, G. L. "Impotence Treated by Mechanotherapy," *Proc. R. Soc. Med.,* 52 (1959), 872-874.

Salzman, L. "*Premature Ejaculation," Int. J. Sexol.,* 8 (1954), 69-76.

Seid, B. "Gonadotropic (HCG) Treatment of Impotence: Results in Fifty-five Cases," *Va. Med. Mon.,* 89 (1962), 178-181.

Semans, J. H. "Premature Ejaculation: 'A New Approach'," *South. Med. J.,* 49 (1956), 353-357.

Spiegal, H. "Is Symptom Removal Dangerous?" *Am. J. Psychiatry,* 123 (1967), 1279-1283.

Taylor, G. R. *Sex in History.* New York: Vanguard, 1954.

Taylor, R. W. A *Practical Treatise on Sexual Disorders of the Male and Female.* Philadelphia: Lea Brothers, 1900.

Tunnadine, L. P. D. *Contraception and Sexual Life.* Philadelphia: Lippincott, 1970.

Tyler, E. A. "A Simple Working Concept of Psychotherapy," *Med. Times,* 96 (1968), 1022-1027.

----. "A Tolerant Attitude about Human Sexual Behavior," in S. Lewit, ed., *Advances in Planned Parenthood,* Vol. 8, pp. 51-55. New York: American Elsevier, 1973.

Vandervoort, H. and T. Mcilvenna. *You Can Last Longer.* San Francisco: Multi- media Resource Center, 1972.

Vincent, C., ed. *Human Sexuality in Medical Education and Practice.* Springfield, Ill.: Charles C. Thomas, 1968.

Wahl, C. W., ed. *Sexual Problems: Diagnosis and Treatment in Medical Practice.* New York: Free Press, 1967.

Wershub, L. P. *Sexual Impotence in the Male.* Springfield, Ill.: Charles C. Thomas, 1959.

Wolpe J. and A. A. Lazarus. *Behavior Therapy Techniques.* New York: Pergamon, 1966.

Notes

1 Hereafter in this chapter "her," "she," and "herself" will be used arbitrarily to avoid the repetitive, clumsy use of "her/him," "she/he," "herself/himself."